| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000814 | A. BUILDING: _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEDDINGTON OAKS | 2223 WEST HEDDING AVENUE PEORIA, IL 61604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Complaint #1821196/IL 100502 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure violations:<br><br>300.1210b)<br>300.1210d)2)<br>300.1210d)6)<br>300.1220b)3)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000814 | A. BUILDING: _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEDDINGTON OAKS | 2223 WEST HEDDING AVENUE PEORIA, IL 61604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to appropriately transfer one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 being lowered to the floor resulting in hospitalization for bilateral distal femur fracture.

Findings include:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000814 | A. BUILDING: _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEDDINGTON OAKS | 2223 WEST HEDDING AVENUE PEORIA, IL 61604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

R1's electronic care plan documents an admission date of 7/5/2012. This same care plan documents the following: "Problem start date: 12/29/16, edited 2/7/18; Category ADL (Activity of Daily Living); Staff to utilize 2 assist when resident appears weak. See section G of MDS (minimum data set assessment) for current ADL status."

R1's most recent electronic MDS dated 12/18/17 documents the following under Section G, Functional status: Transfer 3 (Extensive assistance-resident involved in activity, staff provide weight-bearing support and two plus physical assist).

The facility's Event report dated 1/24/18 at 6:45 PM documents the following: "Called to shower room at 6:45 PM by CNA (V2, Certified Nursing Assistant). Observed R1 sitting on the floor. CNA (V2) reports during transfer from wheelchair to shower chair , R1 went to sit down before shower chair was under her. V2 gently lowered R1 to the floor. R1, alert and confused (per her usual).

On 1/25/18 at 1:58 AM, R1's local ambulance record documents the following: "Staff relates R1 was last seen at her normal earlier in the day. Staff related the patient has a history of Dementia, Anxiety and Hypertension. Staff relates patient has not been sick lately and is bed confined." This same record documents R1 able to move upper extremities freely but did not move lower extremities. R1 transferred to cot via sheet from the nursing home bed. Upon arrival to the local hospital emergency room R1 was transferred to the bed via sheet. R1 yelled both times she was transferred.

R1's local hospital emergency room record dated 1/25/18 at 2:26 AM documents the following

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000814 | A. BUILDING: _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEDDINGTON OAKS | 2223 WEST HEDDING AVENUE PEORIA, IL 61604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

under a physical exam section: "Left hip and knee appear tender to palpitation. Bruising noted to left lower leg and small abrasion to left shin. Petechiae noted to left lower leg." This same form documents the patient also seems to have pain around her left knee and femur. Radiology report (Xray) of the left femur reveals displaced distal femur fracture and per EMS (local ambulance) ," R1 yelled when repositioned and moved . Patient screams when legs are touched or repositioned." R1's Orthopedic consult note dated 1/25/18 documents the following: "R1 is a 89 year old female with history of fall at a skilled nursing home resulting in inability to walk and deformity at left knee. R1's hospital record documents: CT (Computerized Tomography) right knee, impression: Mildly comminuted, displaced distal right femoral metaphysical fracture, with extension to involve the patellofemoral articulation.: CT left knee impression: mildly comminuted, displaced fracture of the left distal left femur with extension to the patellofemoral articulation and nondisplaced left patellar fracture.

The facility's Progress notes document R1 returned to the facility on 1/30/18. The same form documents the following: "R1 has bilateral leg immobilizers in place and is totally NWB (non weight bearing), has numerous staples in place to both legs, has foot protectors in place. R1 is comfort measures only." R1's progress notes dated 2/7/18 at 5:44 PM documents the following: "resident noted without respiration or pulse, cyanotic, and unresponsive."

The local County Coroner Physician Report documents R1 died on 2/7/18 and documents the cause of death was the following: Bilateral Femur Fractures, Impact/contact resulting from fall. The same form documents the approximate interval

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000814 | A. BUILDING: _____ B. WING _____ | C 02/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEDDINGTON OAKS | 2223 WEST HEDDING AVENUE PEORIA, IL 61604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

between onset and death was immediate. This form also documents cause of death as Anoxic Encephalopathy with approximate interval between onset and death as weeks.

R1's physician progress note dated 1/31/18 documents the following: "R1 is seen today for acute transition from hospital after fall in shower. She underwent surgery for gamma nail and screws. Returned with Hospice services. R1's physician note dated 2/2/18 documents the following under a section titled history of presenting illness: "Patient is 89 year old female admission to Hospice after fall femur fracture open reduction internal fixation. Patient is on comfort measures and bedrest.

On 2/26/18 at 2:30 PM, V3/RN (Registered Nurse) stated on 1/24/17, V3 answered a call light and found V2/CNA (certified nursing assistant) sitting on the floor with R1 in the shower room. V3 (RN) stated V2 reported that when V2 went to stand R1 up, R1 didn't stand well so V2 lowered R1 down her leg to the floor. V3 stated that R1 was a 1-2 person transfer "depending on who was working."

On 2/27/18 at 10:40 AM V2, CNA (Certified Nursing Assistant) stated on 1/24/18 she was gathering supplies to shower R1. V2 stated V2 was going to get another staff member to help her with R1's shower but decided to shower R1 herself.

(A)